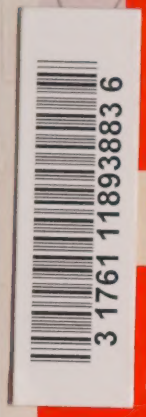

THE COMMUNITY MENTAL HEALTH LEGISLATION SUB-COMMITTEE REPORT

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SECTION ONE: BACKGROUND

The report of the Provincial Community Mental Health Committee, chaired by Robert Graham, was released on September 16, 1988. Entitled **Building Community Support for People: A Plan For Mental Health in Ontario**, the report included 19 recommendations that provided a framework for reforming the mental health system with an emphasis on community-focused support for individuals and their families who must cope with serious or prolonged mental illness.

On September 26, 1988 the former minister of health, Elinor Caplan, publicly endorsed the report and announced several initiatives to begin implementing it:

1. The formation of an implementation group.
2. A request that each District Health Council develop a mental health plan setting out how essential functions would be provided in each district.
3. A process that will culminate in new community mental health legislation to provide a framework for future expansions of the mental health system in Ontario.

In March 1989, the ministry established a steering committee to oversee two sub-committees, one to develop an implementation strategy and the other to assist the ministry to develop draft legislation.

The Implementation Strategy Sub-Committee convened in May 1989 to provide ongoing technical assistance for District Health Councils in planning and developing mental health services in keeping with the report's direction. Over the past two years, District Health Councils have been funded to carry out their local planning responsibilities.

The primary strategy embodied in the "Building Community Support for People" report was to begin to build consensus in the mental health field around a common set of goals and a clear policy direction. This was felt to be necessary due to the concern continually raised in the field that provincial psychiatric hospitals, psychiatric units in general hospitals and community mental health programs operated in virtual isolation from one another. The method put forward to build consensus was to use a target population: people with serious mental illnesses.

Since the release of the report, in fact, a great deal of the desired consensus building has taken place. A large number of people from the various sectors of the mental health field have clearly understood the opportunities provided through the "Building Community Support for People" report initiative and have been working to shape local and provincial reform.

A recent newsletter from the Association of General Hospital Psychiatric Services noted that the "Grahamization" of mental health in Ontario has taken place (the "Building Community Support for People" report is known as the "Graham" report). While it is fitting that the responsibility for this change rests with a variety of individuals and sectors, it is also important to note that the dynamic at work and the momentum achieved so far are

fragile. This point has been clearly conveyed to Legislation Sub-Committee members through the consultation process, and gives urgency to the need for a more formal structure (based in legislation) to consolidate current achievements and provide further direction to the mental health field.

This paper has been developed by the Legislation Sub-Committee. Its purpose is to advise the Ministry of Health on the development of community mental health legislation as recommended by the "Building Community Support for People" report.

Recommendation #11 of that report proposed that the "Ministry of Health take a leadership role to develop legislation to provide for the essential functions related to a community-focused mental health system, using a broadly based consultation process." The sub-committee's specific mandate included:

1. Providing advice to the Ministry of Health regarding the purpose and scope of community mental health legislation.
2. Assisting the Ministry of Health to define and conduct a consultation process with major interest groups.
3. Reviewing input received through the consultations and advise the Ministry of Health on issues and concerns raised.
4. Assisting the Ministry of Health to develop draft legislation.
5. Providing advice on other matters as requested by the steering committee.

The participants of the Legislation Sub-Committee are listed in **Appendix A.**

SECTION TWO: THE CONSULTATION

A) THE PROCESS

The Legislation Sub-Committee was convened in May 1989 and continued to meet approximately once a month. As part of its work, the sub-committee developed a consultation document for circulation and a consultation plan.

The consultation document (See **Appendix B**) provides a brief summary of the "Building Community Support for People" report and identifies possible roles and goals of legislation. The document asks questions about approaches to handling a variety of issues in legislation.

The document received wide distribution and written and oral submissions were requested through a series of public meetings held in communities throughout Ontario. These meetings were organized on a regional basis with the assistance of District Health Councils, members of the Federation of Community Mental Health and Addictions Programs, the Canadian Mental Health Association, local general hospitals and the provincial psychiatric hospitals. These organizations were also asked to make a special effort to attract the interest of consumer/survivors and to encourage them to attend these meetings.

This approach was approved and the consultations commenced in April 1990. Sessions were held in:

- Hamilton
- Kingston
- Thunder Bay
- Ottawa
- Sudbury
- London
- Toronto

Separate sessions were held for families, consumers/survivors and providers at most consultations.

Two special consumer/survivor consultations were held in August 1990 at:

- The Parkdale Activities and Recreation Centre, Toronto.
- The Hamilton Psychiatric Hospital.

Written submissions in response to the consultation document were received from approximately 150 local organizations, although there were more than 400 presentations heard.

One of the major themes of the "Building Community Support for People" report is the involvement of consumers/survivors in all aspects of mental health planning, program

design, implementation and evaluation. Consumer/survivor involvement in public consultations were therefore essential and of great concern to the committee. With the best of intentions the sub-committee embarked on its consultations but found a variety of problems and obstacles to meaningful involvement by consumers/survivors.
As time went on, some of the difficulties being experienced were addressed, but not all. The consultation process was a powerful learning experience for sub-committee members, both in terms of people and process. The knowledge gained from the process will be extremely valuable in enabling the Ministry of Health to "do it right" in future consultations. The knowledge gained from the people at the consultations form the basis of this report.

Although a number of submissions raised issues related to children's mental health services, the sub-committee felt that these issues were beyond the scope of its mandate.

B) RESULTS

Consumers/Survivors
What we heard in the consultations was unmistakable and poignant. Many psychiatric consumers/survivors in Ontario have been condemned to a life of poverty because of reactions to their illness. Most people who spoke to the sub-committee members have experienced at least two levels of trauma - first, their illness; and second, their hospitalization or "treatment". In fact, people are disabled both by their illness and by the mental health system. We also heard many frightening stories of the disabling results of psychiatric medication.

The pervasive effects of stigma remain the single biggest problem faced by mentally ill people in Ontario in 1991. Stigma has many faces - fear, prejudice, ridicule, and discrimination. These people are not aliens. They are our neighbours, our siblings, our children, our co-workers. Because of stigma, they are often alienated citizens. People need housing, jobs, income, and crisis assistance. People need services that are helpful to them in their real-life situations. People do not need services that define their needs for them.

One consumer/survivor concluded her story this way: "Life is precious and wonderful. But always, I am walking the edge. Just a step away is an endless black pit of despair and hopelessness and the knowledge that, at some time, with no warning, I will need to reach out for help and it may not be there. Please help it be there for me."

Families
We also heard many moving stories from families about their experiences. Many seriously mentally ill people in Ontario are cared for primarily by their own families and these families must find a way to cope with tremendous stress and anguish and disruptions in their lives. Families need support and they need alternatives to their present realities.

Representation of families in co-ordination, planning, delivery and evaluation of services was advocated. Relatives talked of being excluded from the mental health system, especially when it came to discharge of their family members from hospital. They experience stigma in several ways, one of which was being seen as the cause of the mental illness.

Parents shared their stories. One said:

"... And I will never, you know, have a complaint against the people that worked with him. They were all wonderful. They did everything that they could. And I think that everybody that I ever met, you know, really cared about him - tried. But what didn't work for them was the system. The system wasn't right. The system didn't allow them to communicate with each other, which didn't ensure that they had to communicate so that they all knew what was happening".

Service Providers

Those who provide psychiatric services had many and varied ideas to offer about the system. Often they expressed the frustration caused by inadequate funding, few services, and a lack of personnel. Some spoke of legislation as a means to legitimize the community mental health sector and establish standards. They spoke of partnership, of a system where decisions were made by local communities, a system that didn't produce conflicting policies, and legislation that wasn't onerous. They spoke of a system that would address the gaps in service, special needs, and service problems in rural areas.

One presenter challenged our committee to honour the pain in people's lives by transforming it into a process leading to "deeper meaning and solid change" for both those people and the system:

"If you don't listen to these stories of what people have been through, then take them and make something of them, then anything else you do doesn't matter".

Another presenter left us with the solemn reminder, "Bad legislation may be worse than no legislation at all."

Native Concerns

During the consultation process, we received a presentation outlining the concerns of native Ontarians regarding mental health services in their communities.

As a cultural group, natives are facing rapid change, which is an acculturation process that places young native people in value-conflict situations. Family units have suffered as a result of an education policy that placed children in residential schools. Native mental health counsellors do not have adequate training to cope with the seriousness of our current mental health problems in the community.

The committee endorses five recommendations, listed in **Appendix C**, put forward by the Nishnawbe-Aski Nation.

Problem Statements

The sub-committee considered the results of the consultation hearings and submissions received. The consultations and submissions did not provide clear answers or consensus in response to the 14 questions posed in the consultation document. The sub-committee developed a list of statements of the problems with the current mental health system based on the results of its consultations and deliberations. These problems are:

- Consumers/survivors of the mental health system experience a poor quality of life. The stigma of mental illness has rendered them second-class citizens who have extreme difficulty in obtaining the common essentials of life.
- Negative attitudes towards people with serious mental health problems lead to discrimination and denial of basic rights.
- Ontario's mental health system does not have a shared vision or shared values and goals to guide its development with respect to people with serious mental illnesses.
- Services and government have difficulties addressing the related social and environmental factors which can contribute to the onset or outcome of a serious mental health problem.
- Appropriate housing, income, employment and crisis assistance are not readily available for people with serious mental illnesses.
- Consumers/survivors and their families are not empowered, involved or represented appropriately in the mental health system.
- Families of people with serious mental illnesses are not adequately supported in providing care to their family members.
- Services are not driven by the needs of people with serious mental illnesses. Priority and funding is not always given to those with the greatest need.
- Overall funding and funding levels for mental health services are inadequate and not well controlled in all sectors.
- Although local planning is improving, it has not evolved significantly to shape a provincial mental health plan. Relevant co-ordination, accountability and evaluation systems are still underdeveloped.
- There is lack of co-ordinated data collection.

The Sub-Committee's Statement on Partnership

The sub-committee recognized through the consultation process that the concept of equal partnership would not be realized unless significant support and increased opportunities were provided to consumers/survivors within the proposed mental health legislation and through ministry policy.

The following report and recommendations, therefore, place major emphasis upon the enunciation and guarantee of consumer/survivor rights, and ensure that consumers/survivors and families are involved significantly in system-wide, program and individual service-plan decision making.

The sub-committee is hopeful that by putting forward these recommendations some of the historical imbalance in the service system will be rectified and equal partnership will become a reality.

SECTION THREE: RECOMMENDATIONS

Recommendation #1

The proposed mental health legislation should be based on the following values:

- CHOICE - People with mental health problems should have a range of choices about their lifestyles that is at least comparable to that of other community members.
- DIGNITY - The mental health system should always seek to maximize and respect the choices of the people it serves.
- SELF-DETERMINATION - Competent mental health service users should be enabled to exercise autonomy in decision making and their decisions should be respected by service providers. An incompetent mental health user should be able to choose his/her substitute decision-maker, who should be guided by the wishes expressed by the user while competent or, if no such wishes exist, by the person's best interests.
- LIBERTY - Maximizing freedom is consistent with providing a range of choices and respect for the individuals' decisions. Those with serious mental illnesses should receive treatment in the least restrictive environment with the least intrusive intervention possible.
- AFFIRMATION OF HUMAN RIGHTS AND NON-DISCRIMINATION - General human rights should not be curtailed for persons with mental health problems without legally acceptable justification.
- FAIRNESS & JUSTICE - Those with mental health problems should be accorded full procedural protections and rights of review whenever their rights are infringed or choices curtailed.
- PROTECTION FOR VULNERABLE PERSONS - Those who require assistance to protect themselves from abuse, neglect or exploitation should receive such support.
- PARTICIPATION - The voices of service users should be heard in decision making at all levels.
- PARTNERSHIP - Consumers/survivors and family members should be recognized as equal partners with service providers and government in improving the quality of life for persons with mental health problems, including participation in treatment decisions and receiving support for separate consumer/survivor and family organizations.

Recommendation #2

Legislation should ensure that the mental health system addresses the needs of people who have:

a) a significant impairment of thought, mood or perception;

b) symptoms of sufficient severity or continuing duration to cause significant dysfunction in their capacity to maintain relationships and live or work independently; and

c) a serious mental illness as defined in (a) and (b) and other conditions such as substance abuse or developmental handicap (i.e., dual diagnosis).

The sub-committee also recommends that priority for mental health services or supports should be given those who have:

a) the greatest degree of impairment or symptom severity;

b) the highest risk of hospitalization;

c) the greatest likelihood of further deterioration;

d) the greatest difficulty in gaining access to and successfully retaining the basic necessities of life, such as housing, income and social support, and meaningful employment.

Funding policies must reflect the population to be served and target population priorities.

Recommendation #3

The legislation should include a statement of rights that will apply to all people who use mental health services and supports governed by or funded under this legislation:

- the right to be accorded dignity and respect in all contacts with the mental health system, including the right to be free of physical, emotional, mental and sexual abuse, exploitation, neglect and coercion;
- the right to the least restrictive environment and/or least intrusive intervention;
- the right to receive services in one's own community or, if such services are not available (i.e., do not exist), within a reasonable distance;
- the right of access to services appropriate to a person's needs, as identified by that person in consultation with the proposed service provider;
- the right of access to services for people with special needs (e.g., natives, women, dual diagnosis, including those with substance abuse);
- the right to refuse treatment or participation in a program or service without punitive consequences;

- the right to reasonable choice of individual worker or service provider within a service or program;
- the right to a review process, beginning at the local service level, on refusal of admission to, discharge from and complaints about rights infringement within a mental health service;
- the right to participate in the planning, development and monitoring (including evaluation) of the service delivery system;
- the right to choose someone to advocate on one's behalf;
- the right to have one's application to a program considered by self-referral
- the right to have, upon involvement with any mental health service, an individual service plan based on an adequate and appropriate assessment of need, to be reviewed at least once a year. The consumer/survivor would participate in assessing his/her needs and in developing the service plan, and would receive a copy of the plan;
- the right to provide a valid consent to any service received;
- the right to have access to information maintained about him/her by a service, and to have that information treated in a confidential manner; and
- the right to define his/her "family".

Recommendation #4

The legislation should **not** include Outpatient Committal or Compulsory Community Treatment.

Recommendation #5

The sub-committee recommends the government implement its proposed advocacy scheme with haste, and in implementing this system of advocacy, emphasize:

- self-advocacy;
- affirmative action regarding consumers/survivors as advocates, and
- development of advocacy skills by consumers/survivors so that they can participate in decision making in the mental health system; as well as
- systemic advocacy at all levels.

Recommendation #6

The legislation should include a complaint/appeal process regarding admission and discharge from services and complaints about rights infringements within services. The process should begin with internal complaint procedures within programs, but it should also include an independent appeal to an arbitrator or tribunal. The option of a further appeal to court should also be included.

Recommendation #7

The legislation should require that service providers operate services in accordance with:

a) the principles enshrined in this legislation;
b) established documented admission and discharge criteria;
c) accepted standards of care, consistent with existing professional and community standards; and
d) an agreement established between the service and the Ministry of Health articulating the specific roles and obligations of both service providers and the ministry. The legislation should include specific consequences for non-compliance.

Recommendation #8

Legislation should provide that:

a) Where the Minister of Health has reasonable grounds to believe that the health, safety, or welfare of any person or group of persons is at risk in a mental health service governed by or funded under this legislation, or where she has grounds for concern about the management or administration, or general quality of care of the service, permits designation of an officer of the ministry or a person to investigate the mental health service and report to the Minister;

b) The investigation, including visits and inspections, may be carried on without notice to the service where the Minister is of the opinion that it is in the best interests of the persons served;

c) The officer or appointee of the Minister shall have the power to enter premises to examine books, records and other documents, and the condition of facilities and equipment, and to enquire into the adequacy of staff and services, and any other matter relevant to the quality of service or management of the service, or the risks to health, safety or welfare;

d) Upon receipt of the investigator's report, the Minister may appoint an adviser to the service who may make recommendations to the governing body of the mental health service and take such action as necessary to improve the management, administration and quality of care for the users for the service;

e) On the basis of the report, and believing it is necessary to preserve the health, safety or welfare of the people who use the service, the Minister may, by written order without notice to the service, immediately appoint one or more persons to conduct, administer, operate and manage the mental health service for a limited period (e.g., six months). Alternatively or in addition, the Minister may cause the persons who use the service to be moved to a safe location either permanently or temporarily. The service users must give their consent to such a move but,if they are not competent to give such consent, they may be moved without the consent of their legally authorized substitute decision-makers if the situation is an emergency, and the substitutes cannot be reached immediately;

f) There should be a right of appeal by the original owners, managers or board of directors of the service to review this decision;

g) These powers may be delegated to or shared with a local authority/network at the discretion of the Minister.

Recommendation #9

The legislation should include access to the courts for individuals and groups to enforce their rights as articulated in this Act, either through an appeal to court from a tribunal (see Rec. #6) or through an independent right of action. Legal aid should be sensitized to these issues so that funding is made more accessible to people who wish to pursue their rights through legal channels.

Recommendation #10

The sub-committee recommends that the legislation require service providers to report abuse (i.e., physical, emotional, mental and sexual abuse, exploitation, neglect and coercion) of service users by staff members to an official designated by the ministry or to the provincial advocacy organization which will be formed under the proposed *Advocacy Act*. The legislation should incorporate protections for those who report and penalties for those who fail to report.

Recommendation #11

The sub-committee recommends that the Ministry of Health:

a) Direct financial resources to consumer/survivor organizations controlled by consumers/survivors;

b) Support the development of consumer/survivor organizations through a process of community development on a regional/provincial basis;

c) In consultation with affected groups, establish criteria to ensure open access and democratic operation of consumer/survivor groups.

Recommendation #12

The Ministry of Health should develop policies to ensure consumers/survivors participate fully in the mental health system.

The sub-committee recommends the following policies be developed and implemented by the Ministry of Health:

a) An affirmative action hiring policy should be adopted and funded by the ministry to encourage the ministry and services to hire those with direct experience of the mental health system;

b) The ministry should also develop a strategy for employment equity that includes barrier reduction and payment of training salaries for those consumers/survivors who need to upgrade skills to obtain and maintain jobs. This strategy should eventually tie in with a provincial government strategy for employment equity;

c) No "consumer/survivor consultation" should be considered valid unless it can be demonstrated that a series of facilitated discussions, including background and issue clarification, have been carried out to the satisfaction of the consumer/survivor participants;

d) Any organization seeking consumer/survivor representation must facilitate meetings of its target group, and ask that one-third of all board and committee representatives be selected or chosen from and by all members of the target group to represent it. This includes those who are former users, recipients or users of the service at the time or who become users during their terms;

e) Articles of incorporation for agencies should ensure that users/consumers/survivors are able to become members of the corporation with voting rights to elect board members and to stand for elections;

f) Ministry of Health funded agencies in any geographical area should be encouraged to share office space and equipment with consumer/survivor groups;

g) Routinely, board and committee meetings of agencies, committees and coalitions should be open to users and families, unless dealing with sensitive personnel or consumer/survivor issues;

h) Minutes of all board and annual meetings at a particular agency should be posted where all members can read them. The mission statement, purpose and goals, and the name and phone number of the person in charge (as assigned by the ministry), should be posted.

If a definition of consumer/survivor is required for legislation it should be stated as follows: A consumer/survivor is a person with direct experience of serious mental health problems who has used mental health services.

Recommendation #13

The sub-committee recommends that the provincial government develop an employment equity strategy which includes barrier reduction, work accommodation, support, and allocated funds to pay for salaries for training purposes, for those consumers/survivors who need to upgrade skills to obtain and maintain jobs.

Recommendation #14

The sub-committee recommends that the Ministry of Health develop policies to provide financial and other resources to family members who are caregivers for people with mental health problems.

The sub-committee recommends that family members be given the support that is essential to maintaining and enhancing their role as caregivers. This type of support may include counselling, education, respite care, crisis intervention and peer support groups, to name a few.

The sub-committee recommends that mental health services provide opportunities for self-help, support and education for families.

The sub-committee recommends that the Ministry of Health:

a) allocates resources for the development of a network of family organizations to be controlled by family members; and

b) ensures families are significantly represented on all governing bodies responsible for the planning, development, co-ordination, delivery and evaluations of mental health services, and that barriers to such participation be reduced.

If a definition of "family member" is required for legislation it should be stated to include: spouses and equivalents, parents, siblings, children and others having significant involvement with a person who has a serious mental illness, and may include extended family, or those designated by consumer/survivor as family members.

Recommendation #15

The legislation should include a statement of right for family members to be provided information about and be involved in care, treatment and discharge planning of the person with a serious mental illness, if the person agrees to such family involvement.

Recommendation #16

The legislation should include a requirement that consumers/survivors constitute a minimum of one-third of all governing boards of agencies, advisory committees for sponsored programs, and community advisory boards of provincial mental health facilities.

For the purpose of choosing consumer/survivor representatives for those boards/committees, the program or hospital should be required to facilitate meetings of its target group and allow that group to choose its representatives from among its members.

Recommendation #17

The legislation should include a requirement that family members be significantly represented, not to exceed the percentage of consumers/survivors represented, on all governing boards, advisory committees for sponsored programs, and community advisory boards of provincial mental health facilities.

Recommendation #18

The sub-committee recommends that the following principles guide the development, delivery and evaluation of services and supports.

A PARTNERSHIP should be established by consumers/survivors, family members, service providers and government representatives to facilitate all aspects of planning, implementing and monitoring of programs.

Services and support programs should be:

- FLEXIBLE, able to adapt and respond to changing needs;
- ACCESSIBLE to persons in need, including those who are disadvantaged because of particular characteristics, such as age, sex, ethnic or cultural identification, physical or mental disability or legal status, as applicable to the mandate of the program;
- AVAILABLE. as close to the person's home community as possible;
- PERSONALIZED, tailored to the specific needs of the person, who will be fully involved in the development of his/her own care plan;
- RESPECTFUL of the needs and experience of the person, treating him/her with dignity;
- EFFECTIVE, utilizing treatments and programs that work;
- EVALUATED at least once a year to ensure the program is keeping to its mandate and objectives;
- ACCOUNTABLE to service users, the community, other mental health service providers and the government;
- LINKED AND CO-ORDINATED with other local services and supports.

Services and supports should:

- UTILIZE INFORMAL SUPPORT NETWORKS to complement or, if appropriate, to replace traditional services.

Recommendation #19

The sub-committee recommends that the Government of Ontario ensure relevant ministries, levels of government and stakeholders work together to develop provincial strategies (which include long-term financial strategies) to address the following unmet needs of those with serious mental illnesses: housing, income, employment and crisis support.

The Government of Ontario should act quickly to identify ministries to be committed and involved in developing strategies for each of these issues and to ensure that the Ministry of Health is taking a lead in developing all strategies, and that the development of these strategies is started as soon as possible.

Recommendation #20

The Ministry of Health should provide funding to mental health programs to cover transportation costs so that consumers/survivors have access to appropriate services.

Recommendation #21

The sub-committee recommends that the Ministry of Health move toward a **less centralized** mental health system.

Local networks/authorities should be established across the province to carry out a variety of tasks within a provincial framework, including:

Planning

a) To ensure a local plan is developed and revised and local roles, responsibilities and accountabilities are clearly spelled out;

b) To ensure a database is maintained;

c) To identify local priorities; and

d) To plan via a needs-based approach.

Evaluation

a) To establish or enforce standards for all component services and organizations;

b) To evaluate local services and supports, ensuring provincial standards are being met; and

c) To evaluate the effectiveness and efficiency of the district mental health network.

Appeals Process

a) To establish an appeals process for those who feel unjustly denied access to services; and

b) To establish a mechanism for resolving disputes between services and supports and local networks/authorities.

Resource Allocation

a) To ensure that resources allocated within the district conform to the mental health plan; and

b) To ensure that resources meet individual and community needs in the most effective and efficient way.

Representation/System Advocacy

a) To represent district interests in discussions with other district authorities, the Ministry of Health and other sectors involved in mental health issues.

Co-ordination of Local Services and Programs

a) To ensure that coordination of local services and activities occurs, and that resources are utilized effectively;

b) To oversee or facilitate the development of joint initiatives, including collaborative training and educational programs, as local needs dictate;

c) To ensure the establishment of central points for information and (possibly) entry into the system;

d) To ensure dissemination of information on innovative ideas, treatments or programs; and

e) To help eliminate barriers hindering the utilization of component services.

The legislation should empower the minister to assign any or all of the following powers to local authorities/networks:

- to employ people;
- to raise, receive, distribute funds;
- to make agreements with persons or bodies to implement the plan, including co-ordination of services;
- to collect information necessary for planning, implementation, management, evaluation and monitoring; and
- to develop and implement means of evaluating and monitoring agencies and services.

Recommendation #22

The legislation should require that **local mental health** plans be developed by local networks/authorities designated by the Ministry of Health to develop these mental health plans.

The legislation should require the plans to address at minimum, the 11 functions outlined in the "Building Community Support" report:

- identification
- treatment and crisis support
- consultation
- co-ordination
- residential support
- case co-ordination and case management
- social support
- vocational support
- self-help/peer support
- family support
- advocacy

The plans should be developed according to the following principles:

- needs-based planning approach
- consumer/survivor and family participation
- comprehensiveness (including the 11 functions listed above)
- co-ordination (with other key functional areas and within the mental health system)
- integration (provincial psychiatric hospitals, general hospitals with psychiatric units and other community mental health programs)
- accountability (plans must articulate mechanisms for accountability)
- planning is an ongoing exercise

The legislation should include provision for:

- a deadline for designation/approval of planning authority/network;
- a deadline for first plan; if deadline is not met the planning authority may lose its right to plan;
- a requirement for review every year;
- the minister should enact regulations or develop guidelines regarding the structure of a planning authority/network which includes consumer/survivor and family participation.

The sub-committee recommends that resources and financial supports continue to be provided to ensure these plans are developed.

Recommendation #23

The sub-committee recommends that the Ministry of Health should develop a plan **for unification and integration of the mental health system at the provincial level under one point of authority and be responsible for:**

Administration

a) Administration of this Act and other related legislation;

b) Delegation of ministerial authority to specified individuals or organizations;

c) Developing funding and management strategies to ensure integration of services can occur;

d) Ensuring barriers are not created that prevent the implementation of this and other legislation and eliminating other existing barriers;

e) Policy development; and

f) Providing support, advice and help to individual services, supports or authorities.

Local Authorities/Networks

a) Providing adequate funding to local authorities/networks;

b) Overseeing activities of local authorities;

c) Actively eliminating barriers to effective operation of local authority/network services and supports; and

d) Developing partnerships with the local authorities/networks and service and support organizations.

Standards

a) Setting standards for services, programs and other providers of care that will form the basis of evaluation; and

b) Defining standards and directions for local authorities/networks to ensure provincial consistency.

Mandates

a) Ensuring the roles of general hospitals, psychiatric hospitals, community agencies, health science centres, universities and other training facilities are clearly defined.

Planning

a) Working closely with other ministries, especially in the areas of income maintenance, housing and employment;

b) Integrating of planning initiatives with other Ministry of Health or government initiatives;

c) Ensuring that new or special needs that are not being met are addressed; and

d) Maintaining a province-wide database.

The sub-committee recommends that there be a central focus of authority for mental health within the Ministry of Health and that an assistant deputy minister for mental health be designated to ensure a consistent and integrated approach to all mental health services throughout the province.

Recommendation #24

The sub-committee recommends a Provincial Advisory Group that is representative of the key stakeholders outlined in this report be immediately established to advise the Ministry of Health regarding:

- the development and implementation of the "Building Community Support for People" report and this report;
- priorities;
- standards;
- provincial special needs (forensic, etc.); and
- consistency of key stakeholder concepts.

Recommendation #25

The Government of Ontario through relevant ministries should provide adequate funding and funding levels, and a responsive funding process, to enable the mental health system to operate efficiently and effectively.

SECTION FOUR: THE VISION

"... I think you may need to either start with legislating the system, and that has results for the individual, or dealing with legislation around the individual that then has an impact on the system ..." (Hamilton transcript, p. 126).

The sub-committee believes that the mental health system must be focused on meeting the needs of individuals with serious mental illnesses and that the rights of these individuals must be respected and protected.

Mental health problems are perpetuated by multiple social and environmental factors, such as inadequate income, substandard housing, and a lack of employment opportunities. These problems must also be addressed by the mental health system, often in collaboration with other ministries, to enable service users to achieve the best possible quality of life within their own communities.*

An integrated mental health system includes community mental health programs, consumer/survivor-driven services and supports, services and supports for families, general hospital and psychiatric hospital services, as well as government. Through **partnership**, all of these stakeholders must work together at both the local and provincial levels, in all activities. To provide a well co-ordinated, accountable system within local communities,* there will need to be increased local control over planning, monitoring and funding. This will require the establishment of local authorities/networks with clearly defined responsibilities.

Finally, the mental health system will need to be funded adequately with direct access and open communications between all levels. The sub-committee proposes the establishment of a Provincial Advisory Group for mental health to oversee the many changes.

* A community may be defined as an "identifiable, self-conscious group with shared common interests. Communities may or may not have a territorial base, and they vary in their level of self-sufficiency. The concept can include culturally or occupational defined groups." (From: **A Vision of Health: Health Goals for Ontario. Premier's Council on Health Strategy** (1989).

A) VALUES

The following values should guide all policy and legislative provisions regarding rights of and services for persons with mental health problems:

- CHOICE - People with mental health problems should have a range of choices about their lifestyles that is at least comparable to that of other community members.
- DIGNITY - The mental health system should always seek to maximize and respect the choices of the people it serves.

- SELF-DETERMINATION - Competent mental health service users should be enabled to exercise autonomy in decision making and their decisions should be respected by service providers. An incompetent mental health user should be able to choose his/her substitute decision-maker, who should be guided by the wishes expressed by the user while competent, or if no such wishes exist, by the person's best interests.
- LIBERTY - Maximizing freedom is consistent with providing a range of choices and respect for an individual's decisions. Those with serious mental illnesses should receive treatment in the least restrictive environment with the least intrusive intervention possible.
- AFFIRMATION OF HUMAN RIGHTS AND NON-DISCRIMINATION - General human rights should not be curtailed for persons with mental health problems without legally acceptable justification.
- FAIRNESS & JUSTICE - Those with mental health problems should be accorded full procedural protections and rights of review whenever their rights are infringed or choices curtailed.
- PROTECTION FOR VULNERABLE PERSONS - Those who require assistance to protect themselves from abuse, neglect or exploitation should receive such support.
- PARTICIPATION - The voices of service users should be heard in decision making at all levels.
- PARTNERSHIP - Consumers/survivors and family members should be recognized as equal partners with service providers and government in improving the quality of life for persons with mental health problems, including participation in treatment decisions and support for separate consumer/survivor and family organizations.

B) MAJOR THEMES/PRINCIPLES

The sub-committee envisages a consumer/survivor-centred mental health system focused in the community for persons with serious mental illnesses. This system is characterized by choices, self-determination, consumer/survivor involvement and partnership with key stakeholders at all levels with the support of alternate services. The system is capable of assisting people to live satisfying lives in the community and to avoid institutionalization to the greatest possible extent.

The sub-committee envisages the following major themes or principles that will underpin the continuing development of the mental health system:

1. There is a shared vision, shared values and goals to guide the development of the mental health system in Ontario.
2. "The person" with a serious mental illness is the main focus of the mental health system, for whom values, principles, rights, plans and delivery of services and supports are developed and implemented.

3. Consumers/survivors and their families are empowered to take charge of the process of change in their lives.

   - Consumer/survivor organizations and family organizations are financially supported in their activities as providers of alternative services.
   - Individual consumers/survivors, their families, consumer/survivor organizations and family organizations are fully involved and represented in the planning, delivery and evaluation of services and supports.
   - Consumers/survivors work in partnership with their families, service providers and government in the planning, delivery and evaluation of services and supports.
   - Consumers/survivors and, where appropriate, their families, are involved in their own service plans and reviews as they request.

4. The mental health system addresses the multiple social and environmental factors that can contribute to the onset or outcome of a serious mental health problem. Those with the most serious mental health problems are able to obtain the supports and services they require to live with dignity, safety and wellness based on their strengths, preferences and needs.

   - Services and supports are comprehensive, encompassing: mental health services, health care services, financial support, housing, vocational support, recreational services and crisis support. Hence, various ministries, levels of government and professionals are fully in collaboration.
   - Services and support programs are accessible to all those in the target population.
   - Efforts are made to respond to complaints and concerns quickly at the service level in a non-adversarial fashion, before reporting to the ministry, tribunals or the courts.
   - Institutional care and community-based treatment and support services are linked by means of access to and from various processes (e.g., the discharge planning process or a rehabilitation plan).

5. The mental health system is innovative with a flexible design to respond efficiently and effectively to changing needs.

   - Services and supports delivered are co-ordinated and accountable to the target population, local networks/authorities and the Ministry of Health.
   - A provincial mental health plan is developed and implemented. Linkages are formed between ministries (including the Ministry of Health) and other sectors.
   - Planning is consistent at the provincial, local/area, service delivery and individual levels.
   - The local level networks/authorities have responsibility for planning, co-ordination, evaluation and systems advocacy.

- Funding for the mental health system flows from the province to the local/area planning bodies for distribution to local service providers and, in many cases, to individual consumers/survivors, and separate consumer/survivor and family organizations.
- Priority and funding are given to those with the greatest need (i.e., most seriously mentally ill).

SECTION FIVE: THE CONSUMER/SURVIVOR

A) WHO IS THE CONSUMER/SURVIVOR?

Consumers and survivors have been defined many ways; for the purposes of this document a consumer/survivor is a person with direct experience of serious mental health problems who has used mental health services.

B) TARGET POPULATION AND PRIORITIES

People who require mental health services and supports have varying degrees of disability, symptom severity and problem duration. A diversity of approaches will be required to meet their needs, many of which may be best served by non-health sectors of a comprehensive mental health system.

There is concern that if the mental health system is not mandated to serve this population, services and supports may drift to those who are less seriously ill or easier to serve. This should be a funding priority.

The mental health system should address the needs of those who have:

a) a significant impairment of thought, mood or perception;

b) symptoms of sufficient severity or continuing duration to cause significant dysfunction in their capacity to maintain relationships and live or work independently; and

c) a serious mental illness, as defined in (a) and (b) and another condition such as substance abuse or developmental handicap (i.e., dual diagnosis).

Priority for mental health services and supports should be given to those who have:

a) the greatest degree of impairment or symptom severity;

b) the highest risk of hospitalization;

c) the greatest likelihood of further deterioration;

d) the greatest difficulty in gaining access to and successfully retaining the basic necessities of life, such as housing, income and social support, and meaningful employment.

C) RIGHTS AND ENFORCEMENT OF RIGHTS

People with serious mental illnesses have existing rights protection under the **Canadian Charter of Rights and Freedoms**, the **Ontario Human Rights Code**, and the **Mental Health Act**. The Charter protects basic rights to life, liberty, security of the person and equality. Other Charter rights might also be relevant to people with severe mental

problems, but these would be the main ones of relevance. The major protection offered by the Charter is to ensure that governments do not pass unconstitutional laws. It does not apply to private organizations such as employers or landlords.

The **Ontario Human Rights Code** protects consumers/survivors against discrimination in employment and housing. Also, there is now a positive requirement in the Code to accommodate the special requirements of persons with disabilities, although it is subject to some conditions.

The **Mental Health Act** provides procedural and substantive rights protection for persons in psychiatric facilities, but the Act does not guarantee any positive rights such as a right to receive services.

The rights proposed below would be additional to those described above, and would be specific to the mental health service system.

All users of mental health services should be accorded:

- the right to be treated with dignity and respect in all contacts with the mental health system, including the right to be free of physical, emotional, mental and sexual abuse, exploitation, neglect and coercion;
- the right to the least restrictive environment and/or least intrusive intervention;
- the right to receive services in one's own community or, if such services are not available (i.e., do not exist), within a reasonable distance;
- the right of access to services appropriate to a person's needs, as identified by that person in consultation with the proposed service provider;
- the right of access to services for people with special needs (e.g., natives, women, dual diagnosis, including those with substance abuse);
- the right to refuse treatment or participation in a program or service without punitive consequences;
- the right to reasonable choice of individual worker or service provider within a service or program;
- the right to a review process, beginning at the local service level, on refusal of admission to, discharge from and complaints about rights infringement within a mental health service;
- the right to participate in the planning, development and monitoring (including evaluation) of the service delivery system;
- the right to choose someone to advocate on one's behalf;
- the right to have one's application to a program considered by self-referral;
- the right to have, upon involvement with any mental health service, an individual service plan based on an adequate and appropriate assessment of need, to be reviewed at least once a year. The consumer/survivor would participate in assessing his/her needs and in developing the service plan, and would receive a copy of the plan;

- the right to provide a valid consent to any service received (see below);
- the right to have access to information maintained about him/her by a service, and to have that information treated in a confidential manner (see below); and
- the right to define his/her "family".

The sub-committee understands that two general statutes for consent to health services and access to and confidentiality of health information are being drafted by the ministry, and supports the direction of these initiatives.

These include the following essential elements:

Consent to Health Services

1. Valid consent is required for services or treatment; i.e., consent must be informed, voluntary and given by a competent person or substitute.
2. Provisions regarding mental incompetence and substitute decision making:

   a) incompetence findings;
   b) age of competence;
   c) rights information regarding incompetence findings;
   d) independent review of incompetence findings;
   e) who is the substitute decision-maker? (in order of priority):

      - court-appointed guardian
      - patient representative appointed under The Mental Health Act (durable power of attorney)
      - nearest relative
      - last resort public official (as Official Guardian under The Mental Health Act);

   f) mechanism for drawing up a durable power of attorney for health services;
   g) scope of substitute authority (e.g., not non-therapeutic matters); and
   h) criteria for substitute decisions (in order of priority):

      - instruction in durable power of attorney
      - ascertainable wishes when competent
      - best interests.

3. Exception to consent for emergencies.

Health Information

1. Right of access to your own health records.
2. Exceptions to own right of access limited to situations where access would create a danger to self or others. (Legislated criteria and safeguards.)
3. Independent review procedure regarding denial of own records.
4. Right to copies.

5. Copies not costly.
6. Right to correct own records, or have disagreement formally noted.
7. Disclosure of records to third parties by patient consent only, except where law permits otherwise.
8. Exceptions to patient-controlled disclosure limited. (Legislated principles and safeguards.)
9. Standards regarding collection of information.
10. Advocates' files kept in health facilities to be confidential; i.e., staff not to have access.

Service Provider Duties

Service providers should be required to develop individual service plans where requested by a user, with the participation of the user and his/her family where appropriate, based on an assessment of the person's needs in which the person has participated actively.

To ensure that service users are provided with information about their rights to participate in needs assessment and service planning, service providers or case co-ordinators should be required to provide clear evidence of a person's informed participation in needs assessment and service planning (e.g., a signed statement).

Service providers should be required to report abuse (i.e., sexual, emotional, mental and sexual abuse, exploitation, neglect and coercion) of service users by staff members, and protection of those who report abuse should be provided (for both service users and staff). Those who report abuse should be protected, both service users and staff, and those who do not report abuse should be subject to penalties.

Outpatient Commitment/Compulsory Community Treatment

The vast majority of those who presented or submitted responses in the consultation process were against the inclusion of any process for compulsory community treatment in legislation. The general arguments made on both sides are presented below. Detailed reviews are available from the Community Mental Health Branch or legal counsel.

Pros:

- outpatient committal could be a preferable and humane alternative to hospitalization
- could prevent hospitalization for people who refuse to recognize deterioration of their mental state

Cons:

- enforcement problems - makes service providers into police officers
- very real danger of abuse of the power
- removes the incentive to provide needed community-based services
- defeats the movement toward empowerment of consumers/survivors
- defeats the voluntary nature of community programs which is essential to recovery of mental health and self-control
- offends general human rights principles
- evidence does not indicate that outpatient committal achieves what it claims to achieve (i.e., research does not bear out validity)

It is **strongly recommended** that Outpatient Committal or Compulsory Community Treatment ***not*** be included in legislation.

OPTIONS FOR ENFORCEMENT OF RIGHTS

a) Advocacy System

In December, 1990, the Government of Ontario announced that it would take action to protect vulnerable adults and that the centrepiece of this initiative would be the **Advocacy Act**. This Act will provide a province-wide system of non-legal social advocacy for vulnerable adults. The advocacy system will deal with rights, personal care, and systemic concerns. Its aims are to allow the concerns of vulnerable adults to be heard and their rights to be protected.

It is envisioned that three kinds of advocates - rights advocates, case advocates, and systemic advocates - will be regulated by an independent advocacy commission, whose members will be appointed by Order-in-Council on the advice of a committee of vulnerable adults.

The sub-committee supports this initiative and urges speedy implementation of this system. We would further recommend that the rights outlined previously be enforced under such a system of advocacy. Further, the sub-committee recommends that emphasis should be placed on:

- self-advocacy;
- affirmative action regarding hiring consumers/survivors as advocates;
- development of self-advocacy skills to reinforce consumer/survivor involvement and control; and
- systemic advocacy to address broad policy issues and system-wide problems.

It is also essential that advocates' files be highly confidential, and that advocates have a right of access to their clients where they live and work. Consumers/survivors must feel that they can speak with advocates without fear of repercussion or worker access to advocate files.

b) Complaint/Appeal Process

Program staffs should be required to develop written internal complaint procedures regarding their services which will be made known to users upon admission and at critical decision points. The process of complaint or review should be simple and user-friendly (e.g., use alternatives to written complaints, or provide advocates to assist with the process). For example, regional bodies with authority over services could hear complaints regarding those services within their regions, with an advocate's assistance where the complainant wishes it.

For an additional independent appeal, it would be possible to have either an arbitration model, where the parties in conflict choose someone to resolve the issue, or an administrative tribunal which would be defined in legislation and appointed by the government to hear appeals. The Provincial Ombudsman would constitute a fourth level of appeal from the decision of a tribunal. The possibility of an appeal to court from the decision of an arbitrator or tribunal is recommended.

An unlegislated appeal mechanism currently exists for decisions regarding provision of vocational rehabilitation and addictions services in several mental health and addictions programs. This model could be revised and extended to other types of programs, or a different model could be developed. (The current VRDP appeal mechanism would probably be replaced by the appeal process implemented in this legislation.)

The sub-committee agrees that a speedy resolution to complaints is highly desirable for all concerned. To this end, the legislation should include clear time limits on each stage of the process.

c) Systemic Enforcement

In addition to the advocacy system and the individual complaint/appeal process described above, the sub-committee considered several options for ensuring that service providers fulfil their duties and responsibilities under the Act. Having considered the pros and cons of the options, the sub-committee recommends that the legislation include provisions regarding agreements between the ministry and providers and a private right of action.

The sub-committee rejects individual contracts between users and providers, licensing of services, and criminal penalty provisions as means of enforcing rights and obligations under the Act.

i) Agreements between ministry and service providers

The ministry should develop agreements with service providers specifying the consequences that will follow if rights are not adequately protected and respected. Monitoring and rights enforcement could be made part of the ministry's regular evaluation of services.

These agreements should include:

- statement of services the provider is committed to providing;
- a requirement that the statement of services be posted for observation by service users;
- a commitment of the provider to respect the rights of individual service users as described in the Act;
- funding and other support to be provided by the ministry; and
- power for the ministry to conduct an evaluation, audit or investigation of the service provider where there is cause to believe that the agreement is being breached by the provider.

Pros:

- flexible and responsive

Cons:

- may not be perceived as sufficient guarantee of rights by consumers/survivors
- subject to change by government officials without public input or debate

ii) Access to courts
The sub-committee believes that consumers/survivors and families should have recourse to the courts to enforce their rights as articulated in this legislation. This may be achieved either through an appeal to court from decisions made by arbitrators or a tribunal as recommended in section (b) above, or through an independent right of action. For this purpose, class actions should be possible to allow groups of consumers/survivors to pursue legal action, and legal aid funding should be made available for class action suits by consumers/survivors.

Pros:

- allows for creative interpretation of the statute
- allows principles to be developed over time by common law approach
- sensitive to individual, unforeseen situations

Cons:

- remedies likely to be too restrictive to accomplish improvements in quality of life and services
- uncontrollable from the service provider's and government's points of view
- expense of litigation; inaccessibility of legal system
- common law of negligence may be sufficient to cover this area

iii) Power of the Ministry of Health to investigate and take over
The legislation should include powers for the Minister of Health to investigate mental health services where she has reasonable grounds to believe that there are serious management problems or where the health, safety or welfare of any person or group of persons is at risk.

In addition, the Minister should have the power to place a substitute manager in charge of the service until the problems are solved, or until new management can be found for the service. She should also be able to take whatever action is necessary with regard to vulnerable persons who are at risk to ensure their safety and well-being. This may include offering them alternative accommodation or moving them to a safe place.

Existing provision in the ***Public Hospitals Act*** (sections 7a and 7b), the ***Health Facilities Special Orders Act*** and the ***Mental Health Act*** (Section 5) are examples of the powers and duties which should be incorporated. A key requirement would be that the Minister have reasonable grounds to believe a service provider agreement is being breached or that there are other serious problems which warrant an investigation and/or takeover. The scope of the investigation and powers of the investigator should be broad and should allow for unannounced visits and unobstructed access to facilities, equipment, records, staff and service users.

It is imperative that due process safeguards be included to allow the service or organization to challenge the action taken by the ministry and to re-gain control over its operation where appropriate.

The legislation should also allow the Minister, at her discretion, to delegate all or part of this investigation and substitute management function to a local authority where one exists.

Pros:

- allows the ministry to take quick and decisive action to protect people in an emergency
- provides a safety valve for unexpected situations such as the resignation of the entire board of an agency
- provides an effective response that minimizes disruption to vulnerable persons in care

Cons:

- if cast too broadly, power could be abused to harass advocacy groups or to impose particular management models on programs
- could be perceived as adversarial by service providers
- if cast too narrowly, the power would be ineffective to discover and stop the most troublesome abuse situations

iv) Contracts between service providers and users to enforce rights

This is the mechanism used in the ***Nursing Homes Act*** to require service providers to commit themselves to recognizing and respecting rights of residents of nursing homes. We are not aware of any other legislation that has taken this approach to rights enforcement.

Pros:

- both parties (i.e., user and service provider) have a clear and standard statement of rights and expectations

Cons:

- problems with enforceability
- contracts between providers and users often are used to contradict or supersede rights users already have

The sub-committee recommends against this option.

v) Licensing of services

Licensing allows the ministry to define conditions under which a service may operate and the expected service delivery in the Act or regulations. Licence may then be given or withheld on the basis of how well the service meets its requirements. Licensing is used by the Ministry of Health for nursing homes, homes for special care, laboratories and ambulance services.

Pros:

- allows for specific requirements to be described in legislation or regulations
- issuing a licence is a serious matter and standards can be enforced

Cons:

- taking a licence away is a serious matter and rights of the licensee (i.e., service provider) are likely to be well protected by a court or tribunal
- does not allow flexibility or quick response in dealing with problematic service providers; other areas of the ministry prefer to have contractual arrangements with service providers

The sub-committee recommends against this option.

vi) Penalties in the Act (provincial offences)

Pros:

- prosecution for an offence is a serious matter and is likely to be viewed seriously by service providers
- sanctions can be significant

Cons:

- problematic to define offences relating to improving quality of life or care
- substantial resources required for investigation and prosecution might be better spent on services and/or advocacy
- questionable whether the long-term effect is to deter rights infringements or to encourage defensive service provision

The sub-committee recommends against this option.

SECTION SIX: CONSUMER/SURVIVOR AND FAMILY EMPOWERMENT

It is paramount that consumers/survivors and family members be empowered to take charge of the process of change in their lives. The "Building Community Support for People" report recommends that a broad cross-section of the community, including consumers/survivors and family members, should have direct input into the planning, development, ongoing operation and evaluation of services. The sub-committee agrees that a community-based system should involve consumers/survivors as key stakeholders in partnership with families, service providers and government in the planning, development and delivery of services.

Elements of empowerment include the provision of policies and resources to:

- Develop a province-wide base of consumer/survivor-controlled and -operated organizations and family-controlled and operated organizations. These organizations will engage in systemic advocacy and provide alternative supports/services;
- Include social and political action groups and education programs, run by consumers/survivors for consumers/survivors and families for families, in systemic advocacy. Alternative supports/services include mutual support groups (traditional self-help), drop-in centres, co-operatively run housing and businesses, creative arts groups, individual advocacy services and information hotlines;
- Promote the full involvement of consumers/survivors in the planning, development and operation of all mental health services;
- Ensure that consumers/survivors and their families, where appropriate and with the consent of the individuals, are included in the development, implementation and review of treatment including individual service plans if used;

A) CONSUMER/SURVIVOR EMPOWERMENT

Consumer/Survivor-Controlled and -Operated Organizations

Currently, consumer/survivor involvement in the "system" is receiving the most attention. Consumers/survivors are playing a more active role in determining planning, development and delivery. This includes influencing the quality of services they receive.

While involvement in the "mainstream" system is extremely important, the development of consumer/survivor organizations is equally important for several reasons. Many consumers/survivors are unwilling to work within a system they believe (rightly or wrongly) has harmed rather than helped them. Those consumers/survivors who do participate in the mainstream system often suspect they are merely "tokens" on boards and committees. Their participation requires a great deal of time and energy, which they give at no small cost to themselves and with little or no guarantee that their efforts will result in any rewards, tangible or otherwise. Furthermore, there are very few consumer/survivor-run organizations and programs to provide training and support for those who are willing to work in the mainstream.

If consumers/survivors are to participate fully in changing the mental health system, they need to be able to work together to define their major goals and to support each other in achieving those goals.

Many consumers/survivors feel both powerless and hopeless as a result of their experiences with the mental health system, particularly hospitals. If they are to become full partners in reforming the system, they need to overcome these feelings. Within consumer/survivor organizations, they are among their peers and free from the role of passive patient or dependent patient. Among peers, shared experience is a powerful tool for overcoming isolation and building self-confidence, which in turn leads to more optimism about working effectively for change. Consumer/survivor organizations can support, educate and network among their members which would help prevent the cynicism and burn-out that accompany mainstream involvement. Further, while mainstream services remain a valid model for offering support to people, they should be complemented by the different approach that consumer/survivor organizations represent.

Thus, independent consumer/survivor organizations can provide people with the strength and support they need to participate in mental health reforms, whether within the mainstream system or not.

The "Building Community Support for People" report recognizes the importance of self-help/peer-support groups. It recommends that communities should have such groups as part of their support systems and that these groups should be self-controlled.

For example, consumer/survivor organizations and groups would:

- Assist those consumers/survivors who want to work at providing alternative services to the mainstream mental health services. Such services would include mutual support groups, information hotlines, and co-operatively run housing and businesses;
- Support and network among survivors, as OPSA (Ontario Psychiatric Survivors Alliance) and TPS (Toronto Psychiatric Survivors) are beginning to do;
- Provide support to help to prevent the cynicism and burn-out that often accompany mainstream involvement;
- Provide a variety of consumer/survivor-oriented training programs;
- Reach more consumers/survivors across the province and so create a larger and more representative group of people who are willing to become involved in a variety of ways;
- Engage in systemic advocacy, which will include social and political action groups working to protect consumer/survivor rights and facilitate the expansion of consumer/survivor-orientated supports and services.

To empower consumers/survivors, the Ministry of Health should:

1. Direct financial resources to consumer/survivor organizations that are controlled by consumers/survivors;
2. In consultation with affected groups, establish criteria to ensure open access and democratic operation of consumer/survivor groups.

All consumer/survivor groups and organizations must have the right to choose their own structure. The consumer/survivor movement is a young and diverse one, and so will need time to decide what kinds of structures are best-suited to its various groups and organizations. Some consumers/survivors may choose not to organize themselves along traditional lines, with boards of directors and a variety of committees.

However, since the province will be funding some consumer/survivor organizations, both consumers/survivors and the ministry need to agree on some criteria organizations must meet to qualify for funding. Three basic criteria are that all survivor groups and organizations must be:

a) controlled by consumers/survivors;
b) open to all consumers/survivors;
c) committed to a democratic process and structure.

The ways in which consumers/survivors choose to meet these criteria will be decided by survivors themselves. Both consumers/survivors and the ministry should be as flexible as possible in their decision-making process to ensure that all possible structural models are given equal consideration;

3. Support the development of consumer/survivor organizations through a process of community development on a regional/provincial basis.

Consumer/Survivor Participation in the Mental Health System
The Ministry of Health should develop policies in each of the following areas of potential consumer/survivor involvement in the mental health system to ensure participation of consumers/survivors:

a) staffing
b) board/committee membership
c) general membership input

Several policies would help address systemic barriers that prevent consumers/survivors from participating fully in service planning and delivery. The following are recommended policies:

1. An affirmative action hiring policy should be adopted and funded by the ministry to encourage the ministry and services to hire those with direct experience of the mental health system.

2. The ministry should also develop a strategy for employment equity that includes barrier reduction and payment of training salaries for those consumers/survivors who need to upgrade skills in order to obtain and maintain jobs. This strategy should eventually tie in with a provincial government strategy for employment equity (to be developed).
3. No "consumer/survivor consultation" should be considered valid unless it can be demonstrated that a series of facilitated discussions, including background and issue clarification, has been carried out to the satisfaction of the consumer/survivor participants.
4. Any organization seeking consumer/survivor representation must facilitate meetings of its target group, and ask that one-third of all board and committee representatives be selected or chosen from and by all members of the target group to represent it. This includes those who are former users, recipients or users of the service at the time, or who become users during their terms.
5. Articles of incorporation for agencies should ensure that users/consumers/ survivors are able to become members of the corporation with voting rights to elect board members and to stand for election.
6. Ministry of Health funded agencies in any geographical area should be encouraged to share office space and equipment with consumer/survivor groups.
7. Routinely, board and committee meetings of agencies and committees and coalitions should be open to users and families, unless dealing with sensitive personnel or consumer/survivor issues.
8. Minutes of all board and annual meetings at a particular agency should be posted where all members can read them. The mission statement purpose and goals, and the name and phone number of the person in charge (as assigned by the ministry), should be posted.

Individual Service Plans

The sub-committee believes that each person should be able to demand an individual service plan as a tool for ensuring that his/her needs are met. This will not be mandatory but will require the consent of the person. These plans can be used as an accountability mechanism to ensure follow-up and delivery of services and supports based on individualized needs identified in a plan. The plan must be tied to service delivery via a case manager, resource or other person. How these individualized service plans would be developed and who should be involved is yet to be determined. However, the person should always be involved in the process and there must be review and appeal mechanisms in place. If people have a right to a plan, then the system must be organized to ensure that individualized service plans will be provided when demanded.

B) EMPOWERMENT OF FAMILIES

The sub-committee recommends that the definition of "family member" be broadly framed to include: spouses and equivalents, parents, siblings, children and others having significant involvement with individuals who have serious mental illness, and may include extended family or those designated by the consumer/survivor as family members.

Families, as primary caregivers, are key stakeholders in the development of any proposed legislation. A recent study by E. Fuller Torrey entitled "Care of the Mentally Ill: a Rating of State Programs" indicates that of the 2,000,000 psychiatrically disabled persons in the United States, 800,000 continue to live with their families. That is, many caregivers are family members and those in care are still in contact with their families. Throughout the consultation process, strong support for the involvement of families at all levels of planning and operation of the mental health system was heard. Family members have identified the need for specific services to families, but their primary concern was the availability of a range of services for the mentally ill family member in accordance with the recommendations of the "Building Community Support for People" report.

It is imperative that the Ministry of Health provide support to families who are caring for family members with mental health problems to ensure adequate and proper care through alternative sources. Further, mental health services should provide opportunities for self-help, support and education to families providing care for individuals experiencing serious or prolonged mental illnesses.

The "Building Community Support for People" report defines "family support" as support to be given to family members that is essential to maintaining and enhancing their role as caregivers. This type of support may include counselling, education, respite care, crisis intervention and peer support groups, to name a few.

Family Controlled and Operated Organization and Participation in the Mental Health System

Family involvement on mental health boards and committees received strong support through the consultation process, as did family participation in both evaluation and treatment planning.

Resources should be allocated for the development of a network of family organizations to be controlled by family members.

Families should be significantly represented (not to exceed the percentage of consumers/survivors represented) on all governing bodies responsible for the planning, development, co-ordination, delivery and evaluations of mental health services, and barriers to such participation should be reduced.

The significant service delivery issue that arose repeatedly during the consultations was the expectation that families be involved in treatment planning and be provided with ongoing information regarding the condition and treatment of the mentally ill family member. Mental health service providers should ensure the inclusion of the consumer/survivor and, when appropriate, the family when planning discharge and ongoing support within community programs. Family members should have the right to receive information about and be involved in care, treatment and discharge planning of the person with serious mental illness, if the person agrees to such family involvement.

SECTION SEVEN:
THE MENTAL HEALTH SYSTEM

A) SERVICES AND SUPPORTS

The "Building Community Support for People" report stresses the need to develop a provincial mental health system that will:

- ensure access to services in, or as close as possible to, a person's own community;
- enhance quality of life and quality of care by maintaining people in the community; and
- provide for a partnership between consumers/survivors, families, service providers and government in the planning, development and delivery of services.

The mental health system must be **centred on the needs of the individual**. "Care must be particular and appropriate (to the individual), planned with and for the individual and his family and directed toward individual participation in community life." (Report of the Provincial Community Mental Health Committee, 1988, pg. 8.)

Support for those with serious mental health problems will be provided by a variety of different services and programs. To ensure that these services truly respond to and meet the needs of the target population, each must follow the guidelines listed below.

Every service or support program must:

- Be FLEXIBLE, able to adapt and respond to changing needs.
- Be ACCESSIBLE to persons in need, including those who are disadvantaged because of particular characteristics such as age, sex, ethnic or cultural identification, physical or mental disability or legal status, as applicable to the mandate of the program.
- Be AVAILABLE as close to a person's home community as possible.
- Be PERSONALIZED, tailored to the specific needs of the person, who will be fully involved in the development of his/her own care plan.
- Be RESPECTFUL of the needs and experience of the person, treating him/her with dignity.
- Be EFFECTIVE, utilizing treatments and programs that work.
- Be EVALUATED at least once a year to ensure the program is keeping to its mandate and objectives.
- Be ACCOUNTABLE to service users, the community, other mental health service providers and the government.
- Be LINKED and CO-ORDINATED with other local services and supports.

- UTILIZE INFORMAL SUPPORT NETWORKS to complement, or replace traditional services.
- ESTABLISH A PARTNERSHIP WITH CONSUMERS AND FAMILY MEMBERS to facilitate all aspects of planning, implementing and evaluating programs.

While a comprehensive range of services and supports must be provided, deficiencies in four particular areas were consistently identified during the consultations across the province:

1. A lack of appropriate housing
2. Limited employment opportunities
3. Insufficient income
4. Inadequate crisis services

Addressing each of these deficiencies is essential if consumers are to manage optimally in their own environments and may involve close collaboration with other ministries or funding sources. Each deficiency requires a **provincial strategy** and a provincial commitment with inter-ministerial input to work on solutions. The Government of Ontario should act quickly to identify ministries to be highly committed and involved in developing strategies for each of these issues, and ensure that the Ministry of Health is committed and taking a lead in developing all strategies and that the strategies are developed quickly.

Housing, income, employment and crisis support were identified as the primary unmet needs by consumers/survivors in the course of the consultations. Objectives relating to these primary needs should be incorporated into individualized service plans, local system plans and inter/intra ministry strategies. The mental health system should assist consumers/survivors to meet their needs in these areas by ensuring access to supportive residential services, real jobs and full entitlement to existing income maintenance programs.

Housing

Consumers/survivors and providers agree there is a shortage of suitable housing options for people with serious mental illnesses. De-institutionalization has caused many to be in need of housing. Governments have failed to respond adequately in the development of new supportive housing stock.

The creation of sufficient supportive housing is a joint responsibility of the Ministry of Health and the Ministry of Housing with local planners. Both ministries should participate in developing a provincial housing strategy for this target population, with measurable targets based on identified needs outlined in local plans. This housing strategy should include a long-term financial strategy for the development of sufficient housing suitable for consumers/survivors of mental health services.

Employment
The sub-committee heard that work was necessary for mental health. Employment provides not only income but also a purpose to life, increased self-esteem, and the reduction of stigma. However, the sub-committee also heard that resources are not available and the system makes it difficult for people to acquire and maintain employment.

Assistance in finding jobs, training and retraining for a broad range of jobs with adequate pay, assistance in maintaining employment, flexible re-entry into the workforce, and better supports for those losing jobs were identified as needs during the consultations.

The Ministry of Health should work with other key ministries, levels of government and stakeholders (including employers) to develop a provincial strategy that addresses these needs and can be reflected in local plans. The Government of Ontario should ensure a provincial strategy is developed and act quickly to identify lead ministries. As well, the strategy must look critically at the issue of wages and benefits in combination with income support programs, employment equity, workplace accommodation, and the creation of employment opportunities for the target group.

These are complex issues, not easily solved, largely disregarded, and needing action.

Income
The sub-committee heard that income support policies cause tremendous stress due to inflexibility, inadequate levels of funding, complexity and inequities in benefits. Two messages were heard clearly throughout the consultations.

1. Don't cut off social assistance while a person is hospitalized. This puts his/her housing at risk.
2. Allow people to earn more money while on social assistance or, better still, to keep all money they earn.

The sub-committee realizes income support reform is a massive issue, and it supports the directions of "Transitions," the report of the Social Assistance Review Committee (SARC), in this area. Especially important are the elimination of the two-tiered system and the establishment of one that encourages recipients to move from dependence and exclusion to self-reliance and active participation in community life.

It is important that the Ministry of Health in concert with stakeholders develop a strategy to ensure that the income needs of the target population are well represented in any reforms to the income support system.

Implementation of the SARC report would begin to address the problems facing consumers/survivors with respect to receiving and maintaining an adequate income level.

Crisis Assistance
There is a need for both institutional and non-institutional crisis assistance services; i.e., 24-hour access to telephone or walk-in emergency services, mobile outreach, community crisis shelters and in-patient beds. Community-based crisis centres are needed to provide front-end services.

Funding should be provided to all mental health programs to cover transportation costs for consumers/survivors so that they have access to appropriate services.

B) A CO-ORDINATED LOCAL NETWORK OF SERVICES AND SUPPORTS

The 11 support functions, as outlined in the "Building Community Support for People" report, are:

- identification
- treatment and crisis support
- consultation
- co-ordination
- residential support
- case co-ordination and case management
- social support
- vocational support
- self-help/peer support
- family support; and
- advocacy

These represent the ideal combination of services that a comprehensive mental health system must provide if the many needs of the target population are to be met. Each local area should have regularly reviewed plans adapted to local area needs and resources to ensure that a satisfactory system of services and supports is in place. Resources and financial supports should be provided to enable these plans to be developed.

To achieve the kind of province-wide mental health system we envisioned, it is essential that services meeting these needs are integrated, accountable and planned and that limited resources are used as efficiently and effectively as possible. A well co-ordinated local network of services would have few barriers to utilization of services, with well linked services provided by different sectors working collaboratively and being well integrated with programs of other ministries. Some of this already takes place between individual services in most communities, a process which should be encouraged.

We heard repeatedly, however, that the best way of achieving this is to give local communities greater administrative and financial control over services in their areas. There was general agreement that the most suitable size and geography of these communities was similar to that of current District Health Council boundaries. These are large enough to support a full range of services but small enough to ensure each stakeholder could play a meaningful role in decision making and implementation, and would be responsive to local community and consumer/survivor needs.

This requires the establishment of local mental health networks/authorities in each District. These bodies would not be involved in the direct delivery of services although a part of their mandate would be to ensure component services and programs were well integrated. Other functions would include planning and evaluation, the establishment of

appeal or arbitration processes, resource allocation, and representation of the entire system in discussions with other district authorities/networks and the Ministry of Health.

Members of these local networks/authorities would be drawn from all those involved in providing or receiving services with representation from the broader community. All component services and organizations will be accountable to this body for meeting appropriate standards and fulfilling their role within the local plan.

The specific tasks of the local network/authority within a provincial framework would be:

Planning

a) To ensure a local plan is developed and revised and local roles, responsibilities and accountabilities clearly spelled out;

b) To ensure a data base is maintained;

c) To identify local priorities;

d) To plan via a needs-based approach;

Evaluation

a) To establish or enforce standards for all component services or organizations;

b) To evaluate local services and supports, ensuring provincial standards are being met;

c) To evaluate the effectiveness and efficiency of the district mental health network;

Appeals Process

a) To establish an appeals process for those who feel unjustly denied access to services;

b) To establish a mechanism for resolving disputes between services and supports and local networks/authorities;

Resource Allocation

a) To ensure that resources allocated within the district conform to the mental health plan;

b) To ensure that resources meet individual and community needs in the most effective and efficient way;

Representation/System Advocacy

a) To represent district interests in discussions with other district authorities, the Ministry of Health and other sectors involved in mental health issues;

Co-ordination of Local Services and Programs

a) To ensure that local services and activities are co-ordinated and that resources are utilized effectively;

b) To oversee or facilitate the development of joint initiatives, including collaborative training and educational programs, as local needs dictate;

c) To ensure the establishment of central points for information and (possibly) entry into the system;

d) To ensure dissemination of information on innovative ideas, treatments or programs;

e) To help eliminate barriers hindering the utilization of component services.

It would be left up to each locale to decide how to complete these tasks, depending on relevant demographic, geographic and cultural factors. It is essential, however, that sufficient resources be provided to ensure these tasks are done.

Legislation would then be used to reinforce the development of a less centralized management model.

C) THE PROVINCIAL LEVEL

The Ministry of Health should be responsible for providing funding for services and supports, setting guidelines and standards for these services and for local authorities/networks, and for ensuring these standards are met. The ministry should identify unmet needs and priorities at a provincial level, integrating mental health activities with other initiatives within the Ministry of Health. It should also play the lead role in developing combined programs with other ministries. The ministry should be in regular communication with, and responsive to the needs of, services and supports and local authorities/networks. The ministry should approve the designation of local authorities/ networks and clarify roles of key service delivery bodies.

To ensure consistency throughout the system, mental health and mental health facilities branches should be integrated and accountable to a single assistant deputy minister. A Provincial Advisory Group that is representative of the key stakeholders outlined in this report should be established to advise on the development and implementation of this report, priorities, standards, provincial special needs (e.g., forensic), and the consistency of key stakeholder concepts. This would be complemented by an executive committee responsible for funding, supporting and overseeing the day-to-day operations of the province's mental health system.

The functions of the Ministry of Health should include:

Administration

a) Administration of this Act and other related legislation;

b) Delegation of ministerial authority to specified individuals or organizations;

c) Developing funding and management strategies to ensure integration of services can occur;

d) Ensuring barriers are not created that prevent the implementation of this and other legislation and eliminating other existing barriers;

e) Policy development;

f) Providing support, advice and help to individual services, supports or authorities;

Local Authorities/Networks

a) Providing adequate funding to local authorities/networks;

b) Overseeing activities of local authorities;

c) Actively eliminating barriers to effective operation of local authority/network services and supports;

d) Developing partnerships with the local authorities/networks and service and support organizations;

Standards

a) Setting standards for services, programs and other providers of care that will form the basis of evaluation;

b) Defining standards, directions for local authorities/networks to ensure provincial consistency;

Mandates

a) Ensuring the roles of general hospitals, psychiatric hospitals, community agencies, health science centres, universities and other training facilities are clearly defined;

Planning

a) Working closely with other ministries, especially in the areas of income maintenance, housing and employment;

b) Integration of planning initiatives with other Ministry of Health or government initiatives;

c) Ensuring new or special needs that are not being met are addressed;

d) Maintaining a province-wide database.

D) THE THREE-TIERED SYSTEM

The mental health system would therefore have a common statement of values and principles guiding its evolution and direction with three major levels of activity. These are:

1. The grassroots service delivery level
2. Local mental health networks/authorities
3. The provincial level

Each will have its responsibilities clearly defined (as described previously) and there must be regular and open access in between representatives of all three levels. It is also essential that integration between the psychiatric hospitals, the general hospitals and other ministry-funded mental health services takes place at all three levels. While we envisage eventual integration of all mental health funding, we believe functional integration is a necessary first step towards this goal.

A schematic representation of the relationships between the three levels and their respective responsibilities is outlined in Exhibit 1.

Delivery of Services and Programs

These will be provided by traditional services, agencies and support programs, by services organized by consumers/survivors and families and by other formal and informal community initiatives.

Each service or activity will be guided by the principles outlined earlier and will work closely and collaboratively with other services, agencies and programs. Each sector will be represented on the local authority. Recommendations for program enhancements and plans for new services will be submitted to the local authority as part of the development of a network of services.

Local Networks/Authorities

Each local area will have a body with representation from all sectors responsible for planning, co-ordination, resource allocation, evaluation and systems advocacy. Representatives of this body will meet on a regular basis with representatives of other local authorities and the Ministry of Health at both a regional and provincial level.

The Provincial Level

The provincial level will be responsible for establishing standards, setting priorities, developing and implementing this report and the proposed legislation, identifying specific problems, and ensuring the consistency of key stakeholder concepts (as outlined in this report). It will fund and oversee the day-to-day running of the entire system, playing the leading role in integrating mental health activities with those of other ministries involved in meeting the needs of the target population. It will be guided by an assistant deputy minister for mental health as the central focus of authority for mental health within the Ministry of Health.

THREE TIER MENTAL HEALTH SYSTEM

MINISTRY LEVEL RESPONSIBILITIES

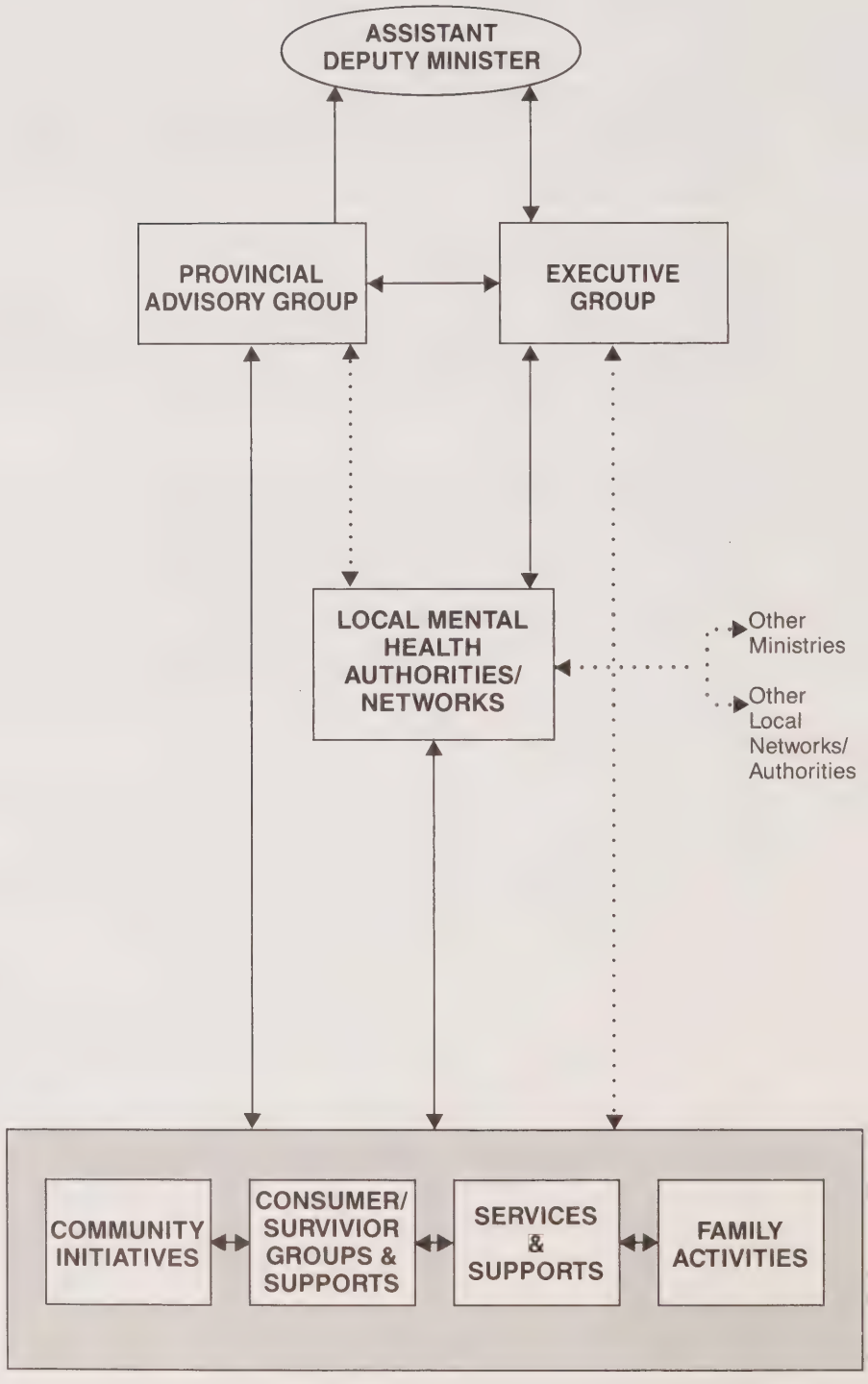
- Administration Including the integration of funding
- Local Authorities/Networks
- Standards
- Mandates
- Planning in co-ordination with other Ministries

LOCAL LEVEL RESPONSIBILITES

- Planning
- Evaluation
- Appeals Process
- Resource Allocation
- Representation/System Advocacy
- Co-ordination of Local Services and Programs

SERVICE/SUPPORT PROGRAM LEVEL RESPONSIBILITIES

- Provision of Services
- Needs Identification
- Linkage with other Services
- Joint Activities
- Mutual Support
- Individual Service Plans



APPENDICES

Appendix A

LEGISLATION SUB-COMMITTEE

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Bev Lever	Co-Chair Director Community Mental Health Branch
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Appendix B

DISCUSSION PAPER
TOWARDS
COMMUNITY MENTAL HEALTH SERVICES
LEGISLATION

JANUARY 1990

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I. INTRODUCTION

This document has been written to stimulate discussion on the development of draft Community Mental Health Services Legislation.

The Legislation Sub-Committee offers this paper as a starting point for you and your group or organization to think about the issues and to give us your opinions and comments. We hope you will take the time to give us your thoughtful input. We are looking forward to a very productive consultation process to help us further develop our thinking on these issues before we begin drafting legislation.

From our experience in working through these issues, we would suggest that you and your group might want to discuss these two basic questions as a starting point:

1. What are the advantages and disadvantages of Community Mental Health Services Legislation?
2. What does your group or organization expect from mental health services legislation? What would you most like to see accomplished in the mental health field?

The paper provides some background information on the Report of the Provincial Community Mental Health Committee (the "Graham" Report) and outlines the possible role and goals of Community Mental Health Services Legislation.

In developing this document, the Legislation Sub-Committee has embraced two important assumptions: that mental health services will increasingly be planned and administered by the communities which they serve, and that the mental health system will be focused in the community. These assumptions are consistent with the overall direction of health care planning and service delivery.

The Report of the Provincial Community Mental Health Committee recommends a balanced mental health service system and a regional approach to service planning and delivery. We offer some suggestions in this paper as to how this might be achieved.

II. BACKGROUND

Report of the Provincial Community Mental Health Committee

In July 1988 the Report of the Provincial Community Mental Health Committee recommended the development of a community focused mental health care system. The report provides a full description of how such a service system is to be achieved, but for your convenience, Appendix 1 to this document provides a summary of the Committee's recommendations.

The report advocates the development of an integrated mental health service delivery system. It also stresses participation by consumers in the planning and delivery of services. Another central theme of the report is increased availability and accessibility of

services across the province. The report recommends that service recipients should have more choices about the kinds of services they will receive, and how and where these services will be delivered. It also explicitly recognizes that services must be flexible and adaptable to effectively respond to the needs of persons with serious mental disorders.

The Report describes the following 11 essential functions and recommends that each District Health Council have a mental health plan by 1991 which sets out how they should be provided:

i) Identification
ii) Treatment and crisis support
iii) Consultation
iv) Co-ordination
v) Residential support
vi) Case co-ordination and case management
vii) Social support
viii) Vocational support
ix) Self-help/peer support
x) Family support
xi) Advocacy

Recommendation #11 proposes that the "Ministry of Health take a leadership role to develop legislation to provide for the essential functions related to a community-focused mental health system using a broadly based consultation process".

In response, the former Minister of Health, the Honourable Elinor Caplan, indicated that she wished to introduce legislation to support the development of a community-focused mental health system as recommended in the report.

Role of Legislation

There is some debate over the potential costs and benefits of community mental health services legislation. Some people are concerned about the finality and rigidity of legislating some aspects of service delivery. Legislation, they claim, may inhibit innovation in developing new programs and service delivery strategies.

Others believe that community mental health services legislation will provide the framework and processes for developing a well integrated and co-ordinated service system. In establishing a better co-ordinated service system, the legislation could describe regional planning processes and identify who should participate, especially consumers and families. Proponents of legislation also anticipate that legislation will help legitimize the community mental health service sector by establishing mental health services as a funding priority and by describing the principles and essential functions of a comprehensive service system. It has also been suggested that legislation could also better establish accountability mechanisms and outline how quality of care can be ensured.

We would like your input on the question of both the role and goals of legislation. As you consider this question, please keep in mind that the legislation will include the statute itself and the related regulations.

Experience in Other Jurisdictions
The overall approach recommended in the "Graham" Report accords with the experience in other jurisdictions where mental health services have been refocused from hospital-centred systems to the community.

For example, legislation has played a variety of roles in the United States. In some states, the legislation has been introduced early in the process of changing the focus of the system, and thus plays the role of setting both framework and process into motion. In other states, there has been an extensive period of development of an integrated system on an informal level, and legislation has been introduced later to formalize what has already been developed and to legitimize its expansion to other areas.

Possible Goals of Legislation
The goals of the legislation might include the following:

1. To ensure the availability of high quality mental health services to residents of Ontario appropriate to their needs and located as close to home as possible.
2. To state the fundamental principles according to which a comprehensive system of mental health services in Ontario will be planned, co-ordinated, administered and delivered.
3. To describe the components of a mental health service system in all areas of the province.
4. To prescribe a planning process and identify responsibilities for the development, monitoring, and evaluation of the mental health service system at the provincial, regional and local levels.
5. To provide a basis for ensuring program accountability for the quality of care delivered by the mental health system, either by prescribing program standards or by some other suitable method.
6. To provide guidelines for confidentiality of, and access to, information about persons using mental health services and for dealing with incompetency and substitute consent issues.

Are there any other purposes for which legislation may be useful? If so, what might they be?

III. PROPOSED FRAMEWORK FOR LEGISLATION

The Legislation Sub-Committee has reviewed a number of approaches to the system for planning, co-ordination and delivery of mental health services. The approaches described in Appendix 2 include a centralized system and three that are decentralized. The issue of the authority vested in a local body is also addressed by these models. The approaches further describe varying degrees of integration in planning, co-ordinating and funding mental health services with other community based health and social services. **They do not represent the full range of possibilities and are presented as examples only**. You may find them useful when attempting to answer some of the questions asked below.

The Legislation Sub-Committee would like you to think about these approaches and to identify any others that you feel that we should consider.

IV QUESTIONS AND ISSUES

1. What should be the scope of the legislation?

   The target group for the legislation could be adults with serious mental disorders and their families. For this purpose, adults could be defined as those over the age of 16 years. The term "mental disorder" may be defined as follows:

   > "a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs a person's behaviour, judgment, capacity to recognize reality, or ability to meet the ordinary demands of life."

   Addictions services and other related issues may not be encompassed by this legislation. Linkages to children's mental health services, operated under the **Child and Family Services Act**, and to addictions programs, could be made explicit in the legislation.

2. How should consumers, family and community members be involved in planning, co-ordination and delivery of mental health services?

   The legislation could include a general requirement that consumer, family and community members be represented on all bodies.

   On the other hand the legislation could establish a minimum requirement for governing boards of organizations which plan, co-ordinate and deliver services to include users or former users of mental health services on the board. Additional minimum requirements could be established for other non-service providers, including family members, advocates, community members and others not directly involved in the provision of mental health services.

3. Should the system for planning, administering, delivering and evaluating mental health services be centralized or decentralized?

   The approaches identified in Appendix II are intended to illustrate how a centralized and decentralized system would look. You may find them of some assistance in answering this question.

4. What should be the geographic unit of a regional system?

   The answer to this question depends upon the mandate and scope of the regional body. Options include District Health Council planning areas, provincial psychiatric hospital catchment areas, municipalities, the regional structure of another service or ministry or some other, new basis for regionalization.

   One option would be to develop demonstration models in selected regions to experiment with different approaches. This approach would allow for development of different models of delegation and service integration.

5. If it were to be decentralized how should a regional mental health/community services authority be structured?

   One approach would be to create a regional structure within the Ministry of Health similar to that of the Ministry of Community and Social Services. Another approach would be to establish an authority separate from that of the Province.

6. What mandate should be given to a regional mental health/community services authority?

   Should a regional authority be responsible for any or all of the following functions: planning, co-ordination, administration, delivery and evaluation of services?

   With regard to service delivery, one option would be for the authority to provide individual service co-ordination, crisis support directly. Other services would be provided on a contract basis with community-based agencies. This option would give the regional board direct control over the use of funds in its community.

   A second option would be to make the regional board a co-ordinating board with all services to be obtained through contracting, including services such as crisis intervention and case management/co-ordination for individuals. The board would become an administrative and monitoring body.

7. How should a regional mental health/community services authority be financed?

   An option is to provide the regional authority with a set amount of funds for all mental health services. Funds for additional new community programs would flow through the regional board, and funding for established community programs should be flowed through the regional board after a phase in period. Funds for hospital services should also be flowed through the regional board after a transitional period. New funds would need to be invested to develop the regional body itself, i.e., to provide staff and facilities, and for some new direct services.

8. Should the legislation guarantee the right to receive services?

   One option is not to formalize the right to receive treatment or services in legislation.

   Alternatively, the legislation could include a duty to provide, or right of access to, mental health services which are located close to where a person lives and which are based on an individualized assessment of need in which the person participates equally with mental health professionals.

9. How should services for individuals with a serious or prolonged mental illness or impairment be co-ordinated?

   Regardless of the system model chosen, co-ordination is a prerequisite to increasing quality of services and cost-effectiveness. Therefore, co-ordination should be an essential function of the system, prescribed in the legislation.

Whether individual co-ordination should be operated according to a case management model or on a multi disciplinary treatment team model is open to question.

10. How should the principles and functions of a co-ordinated mental health service system be incorporated into the legislation?

    Essential services could continue to be provided by psychiatric facilities as specified in regulations (Reg. 609 under ***Mental Health Act***).

    Alternatively, the legislation could outline the principles and functions which must be provided in each geographic area (DHC, or PPH catchment area, or other) and require the planning body to develop a plan for how the functions will be provided, with definite target dates for both the plan and provision of service.

11. Should the legislation include a mechanism for quality control for standards of care and programs? If so, how should they be enforced?

    One option would be to use planning and reporting mechanisms, and external evaluations rather than legislation.

    Another option would be to include standards in regulation with appropriate enforcement provisions.

12. What provisions should there be for record keeping, and confidentiality of and access to records?

    Provisions could follow the scheme contemplated for the proposed Health Care Information Access and Privacy Act. Specific guidelines and forms should be included in this legislation on an interim basis.

13. Should the legislation include provisions for out-patient commitment/compulsory community treatment?

    One option would be not to introduce out-patient commitment or compulsory community treatment.

    Another option would be to provide for conditional release or certificate of leave from hospital.

    A third option would detail out-patient commitment. If a certificate-of-leave or out-patient commitment is to be considered in Ontario, it is recommended that this be included in the ***Mental Health Act***, and not in the Community Mental Health Services legislation.

14. How should the legislation deal with the issues of incompetency and substitute consent?

    There are three potential areas of incompetency that may be of concern in a community program:

    1. Competence to manage financial affairs,
    2. Competence to consent to participation in programs, and
    3. Competence to consent to disclosure or withholding of records.

With respect to management of financial affairs, the effect of not dealing with incompetency specifically in the legislation would be to leave clients under the jurisdiction of the current ***Mental Incompetency Act***, or its replacement following upon the Fram Report.

If, however, programs such as crisis intervention or alternative treatment programs for people with serious mental disorders find themselves confronting the issue of incompetence, they could be designated as psychiatric facilities under the ***Mental Health Act*** for these purposes. In that event, all of the consent to treatment and disclosure of records provisions would apply as if the program were a psychiatric facility. Of course, if the current proposal for a comprehensive health care consent act goes forward, then clients of community mental health programs would be covered under that act.

APPENDIX 1

RECOMMENDATIONS OF THE PROVINCIAL COMMUNITY MENTAL HEALTH COMMITTEE (July 1988)

Recommendation No. 1

That the Ministry of Health adopt the following goals for a comprehensive mental health care system as provincial policy.

a) Ontario develop a mental health system to deliver comprehensive services that:

   i) ensure all residents of Ontario access to mental health services in, or as close to, their own communities as possible;

   ii) place priority on providing support to individuals and their families who experience serious or prolonged mental illness or impairment;

   iii) recognize the multi-dimensional nature of the origin and management of mental illness;

   iv) ensure a balance between institutional and community sectors of the mental health system by providing an adequate supply of a range of formal and informal supports and treatment in order to reduce the need for institutionalization, in response to geographic and population needs;

   v) enhance quality of life as well as quality of care by maintaining people in the community and close to their natural environments; and

   vi) provide access to adequate incomes through work or social assistance.

b) Ensure Ontario's mental health system provides for:

   i) partnership between consumers, their families, service providers and government in the planning, development and delivery of services;

   ii) improved communication and co-operation between ministries and other levels of government;

   iii) a balance between province-wide perspectives and local priorities that encourages flexibility and community innovation; and

   iv) the integration of services provided by health professionals, community agencies, general hospitals and provincial psychiatric hospitals.

Recommendation No. 2

That by 1991 each District Health Council have a Mental Health Plan which sets out how the following essential functions will be provided in each district:

i) Identification
ii) Treatment and crisis support
iii) Consultation
iv) Co-ordination
v) Residential support
vi) Case co-ordination and case management
vii) Social support
viii) Vocational support
ix) Self-help/peer support
x) Family support; and
xi) Advocacy

Recommendation No. 3

That the following principles guide the development and funding of mental health services. Initially these principles should be applied to new or enhanced community mental health services reviewed for funding by District Health Councils between now and 1991.

And that by 1995, mental health services provided by community agencies, general hospitals, psychiatric hospitals and other professionals reflect the following principles in order to qualify for funding:

- Focused in the community: Care is provided in such a way so as to enable individuals to obtain needed support and encourage them to make use of family, friends, and other naturally occurring helping relationships. A broad cross-section of the community including consumers and their families, should have direct input into the planning, development, ongoing operation and evaluation of services.
- Mandated: Communities and government share the responsibility to ensure that a full range of services is provided.
- Comprehensive: A range of services will be available to meet diverse needs and provide for consumer choice about how needs are met.
- Individualized: Care is particular and appropriate, planned with and for the individual and his family and directed toward enhancing individual participation in community life.
- Flexible: Services should be adaptable and responsible to the special needs of identified individuals, groups and communities, and to changing needs over time.
- Accessible: Services should be provided in such a way so as to ensure that they are available to those most in need and that individuals will not experience significant difficulties in using them.

- Co-ordinated: The service system must provide for the continuity of care and ensure that integration takes place at the client, program and system levels.
- Accountable: Supports and services should be monitored, evaluated and adjusted in order to remain appropriate and responsive to changing client needs. Consumers, family members, as well as service providers, are involved in the development, operation and evaluation of services.
- Culturally and geographically relevant: The dimensions of a service system must reflect the unique characteristics of specific communities and target population within them.
- Functionally equivalent: Services are developed with the recognition that a variety of service interventions can meet the same need.
- Use of natural and informal supports: Self-help approaches and natural support systems (that is, family, friends, community) are essential to the maintenance of mental health and to the treatment of mental illness.
- Effective: The mental health plan will encompass more than the narrow range of traditional services. Services will be evaluated in relation to their effects on quality of life as well as outcome measures.

Recommendation No. 4

That by 1991 District Health Councils develop multiyear plans for the provision of mental health services in each district that:

- detail the services to be provided by 1995;
- set measurable objectives in relation to the establishment and operation of services that embody the above mentioned principles and are organized according to the functions of a comprehensive mental health system;
- ensure that the roles of general and psychiatric hospitals are clearly defined and integrated in relation to the provision of services under the plan, and identify specifically the means for the development of linkages between hospitals, community mental health services and other community services;
- reflect the full participation of consumers and family members as well as essential service providers in the planning process;
- have a mechanism to assess needs, recommend reallocation or resources and change the type of services offered so that the service system is responsive to changing needs and reflects the objectives of the plan; and
- include an annual report on progress to date vis-a-vis plan objectives, and recommend new funding initiatives in relation to the plan.

Recommendation No. 5

That the Ministry of Health direct each of the provincial psychiatric hospitals to develop a plan outlining the development of their programs until 1995. These plans should be developed in co-operation with District Health Councils and Area Mental Health Advisory Boards and should include:

- a description of hospital and community-based programs;
- an outline of how these programs are linked with existing community programs and agencies;
- a statement as to how they will be co-ordinated with local planning initiatives; and
- an estimate of the proposed impact on bed utilization.

Recommendation No. 6

That by 1989 District Health Councils develop a priority list for the funding of new or enhanced community mental health services to reflect the essential functions outlined in this report.

Recommendation No. 7

That the Ministry of Health establish Area Mental Health Advisory Boards, comprised of a representative from each District Health Council, to co-ordinate the development of mental health plans by District Health Councils and other groups to:

- assist in developing a more balanced mental health system through the integration of the roles of psychiatric and general hospitals with community-based organizations; and
- develop strategies for more detailed investigations and make recommendations on those special target groups such as youth, the elderly, ethnic groups, natives and other special needs groups which due to the limited time frame, have not been explored in sufficient depth in this report.

Recommendation No. 8

That the Ministry of Health develop a multiyear plan for the financing of mental health services which sets out the funding to be available for the enhancement and development of community mental health services on an annual basis between now and 1991. The plan should specify the amounts required by year to implement an integrated community-focused mental health system between 1991 and 1995 and identify funding mechanisms required.

Recommendation No. 9

That the Ministry of Health notify District Health Councils, before funding submissions are requested, of the amount of money likely to be available in each district for the enhancement and development of services under the mental health plan.

Recommendation No. 10

That the Ministry of Health use the Health Innovation Fund to support demonstration projects related to co-ordination and new models of service delivery in order to develop a more integrated and innovative mental health care system. Projects to be considered could include:

- establishing local mental health authorities;
- encouraging joint ventures between psychiatric and general hospitals and community agencies;
- rural and remote area models of service and co-ordination;
- using primary care settings such as public health units (PHUs), health service organizations (HSOs) and community health centres (CHCs) to provide community mental health services and primary care to persons with serious or prolonged mental illness; and
- services for people with dual diagnosis and other special needs categories.

Recommendation No. 11

That the Ministry of Health take a leadership role to develop legislation to provide for the essential functions related to a community-focused mental health system using a broadly based consultation process.

Recommendation No. 12

That the Ministry of Health establish a Provincial Advisory Committee on mental health to:

- promote the recommendations of this report to consumers, families and service providers across the province;
- help establish and review the activities of any pilot projects undertaken to implement the recommendations of this report;
- review the annual reports of District Health Councils, and Area Mental Health Advisory Boards on the progress made with regard to the implementation of a community-focused mental health care system in each of the six planning areas; and
- report annually to the minister and the Premier's Council on Health Strategy on progress made in relation to the implementation of a comprehensive mental health care system.

Recommendation No. 13

That the Ministry of Health strive to improve communication with and co-operation between the provincial ministries of community and social services, housing, skills development, and corrections as well as federal departments and local governments involved with mental health care programs, policies and funding, including income security.

Recommendation No. 14

That the Ministry of Health support District Health Councils and other planning bodies in the development of mental health plans by providing them with resources to do so.

Recommendation No. 15

That by January 1989, the Ministry of Health, in conjunction with the ministries of colleges and universities, skills development, community and social services, and education, develop a mental health training strategy that recognizes the need - particularly in a community-focused mental health system - to provide continuous training and upgrading to a diverse group of mental health service providers with different professional backgrounds and practice settings, including rural and remote areas.

Recommendation No. 16

That the Ministry of Health develop a strategy for applied research and evaluation in the mental health field, and direct funding of projects in this area.

Recommendation No. 17

That the Ministry of Health develop a strategy to strengthen the presence of mental health professionals in underserviced areas by:

- encouraging the development of local mental health workers in native, francophone, rural, remote and multicultural communities;
- continuing its efforts to attract both francophone and native people into the mental health field;
- providing financial incentives;
- providing professional support, consultation and continuing education; and
- defining specific roles for the province's five teaching centres in providing back-up, consultation, support and student placement.

Recommendation No. 18

To redress the imbalance in the distribution of physicians, the province's five teaching centres should:

- place a greater emphasis in psychiatric residency training programs on community psychiatry, care of the mentally disabled and consultation to community programs; and
- ensure that training programs for family physicians include the utilization of mental health services, principles of psychiatric rehabilitation and problems faced by the elderly and minority groups.

Recommendation No. 19

That the Ministry of Health develop a separate funding strategy for mental health promotion and educational activities to ensure that additional resources are available within communities for such projects.

APPENDIX 2

APPROACHES TO LEGISLATION

The purpose of this section is to provide individuals and groups with some examples of the mental health service delivery system envisaged by legislation. They are meant to illustrate how decisions about the scope of the legislation, the degree to which the system would be centralized or decentralized and the division of responsibilities between the Ministry of Health and any other body would be operationalized.

I. CENTRALIZED SYSTEM

The ministry would develop legislation which regulates existing community mental health programs, but which does not address planning, operation, or evaluation of any hospital services. Co-ordination of services would not be a goal of the legislation under this option.

There would still be questions to be answered about the scope of such legislation, as many of the current community programs are operated by Provincial Psychiatric Hospitals (PPHs) and general hospitals.

Specific Elements:

1. Regional Co-ordination:
   Regional needs identification and planning could be performed by District Health Councils. Services in the community would continue to be monitored and funded directly by the ministry.
2. Planning:
   At the provincial level, the ministry would be required to develop a plan for future development of community mental health services across the province. Specific needs identification and planning for the essential functions to be provided within each community would continue to be undertaken by District Health Councils. Consumer and family involvement in planning could be mandated within the legislation.
3. Financing:
   Financing would remain separate for hospitals and community programs, but community programs could be given some assurance that funding would continue at a particular level.
4. Administrative Framework:
   Administration of community mental health services and hospital services would continue to be separate within the ministry. This would probably mean that the Community Mental Health Branch would continue to administer the community mental health services programs.

5. Quality Control/Program Standards:
   Program standards or guidelines would be developed by the Community Mental Health Branch and included in regulations under the legislation. The enforcement of the standards or guidelines would also be done by the Community Mental Health Branch, probably through regular evaluations and audits and by making funding contingent on meeting program standards. The power to make such standards and regulations would have to be included in the legislation.

II. REGIONAL AUTHORITY FOR COMMUNITY MENTAL HEALTH SERVICES ONLY

The legislation would define the mandate of a regional authority which would assume some of the responsibilities currently vested within the Community Mental Health Branch of the Ministry of Health. The legislation could outline a regional administrative mechanism to co-ordinate community mental health services provided by agencies in various localities throughout the region. The ministry would prescribe the principles, overall direction and priorities for the system to be developed in each area. Service co-ordination at the individual client level would be an essential element of the system. The geographic boundaries of such a body need not be prescribed in legislation.

Specific Elements

1. Regionalization:
   These authorities could be established as an arm of government or they could be incorporated bodies governed by a board which includes service providers and consumers. The mandate of the authority could be (a) to establish individual service co-ordination and crisis intervention functions, either by providing them directly or through contract, and (b) to co-ordinate the development of new community mental health services in the region and administer their funds.
2. Planning:
   Planning for new and expanded services would continue to be the responsibility of District Health Councils. The regional authority would facilitate service planning and co-ordination on a regional basis. The ministry would develop an overall goal statement, policy and direction with respect to development of community mental health services to guide District Health Councils and the regional authorities. This statement would include funding priorities.
3. Financing:
   Community services would continue to be funded by the Community Mental Health Branch with funds for new services flowing through the regional bodies. The flow of funds for established programs through the regional authorities could be phased in over a number of years.
4. Administrative Framework:
   At the regional level, community services should be administered through the regional authority either directly or by contract for newly developed services. Established services would continue to be administered independently and monitored by the Community Mental Health Branch for an interim period.

5. Control/Program Standards:
   Quality control for standards of care and programs would be adopted in regulations and monitored by the regional authority.

III. REGIONAL AUTHORITY FOR ALL MENTAL HEALTH SERVICES

Comprehensive legislation would integrate all mental health services provided by provincial psychiatric hospitals, general hospitals, private hospitals and community agencies at the regional and provincial levels.

As part of this approach, regional bodies would be established with a mandate to develop, provide or contract for services and monitor and evaluate all mental health services within the area, including in-patient hospital services. Local planning would continue to be the responsibility of District Health Councils. A central referral point located in the community could be a feature of this approach.

The development of this approach could be phased in at the discretion of the Minister.

The legislation would prescribe principles, essential functions (services) to be provided by the system, and the administrative framework for the comprehensive system. Legislation could also set out the strategy for transition, including target dates for plans to be submitted, and for transfer of authority and funds to the local or regional authorities.

Specific Elements:

1. Regional Mental Health Authority:
   The legislation would establish the mandate of a regional mental health authority.

   The regional body would be given the authority to develop, operate and contract for mental health services within the region including in-patient services provided by provincial psychiatric hospitals and general hospital psychiatric units. The delegation of authority over services could include the authority over moneys appropriated for those services.

2. Planning:
   The regional mental health authority would provide assistance to local planning bodies and would facilitate the development of a regional mental health services plan.

3. Financing:
   The legislation could facilitate a movement toward the integration of all funding for mental health services for people with serious mental disorders. The specifics of how such a financing arrangement could be worked out would have to be pursued in detail once a decision is made with respect to the basic model to be chosen.

4. Administrative Framework:
   An administrative framework similar to that recommended for the second approach described could achieve the goals set out for this option.

5. Quality Control/Program Standards:
   Quality control for standards of care and programs would be enforced at two levels: the Regional Mental Health Board through contract compliance, monitoring and evaluations; and centrally by the ministry, for evaluation of programs operated directly by the Regional Mental Health Board (e.g., service co-ordination, crisis services) and spot audits on contract and services. Standards for evaluation could be developed by the ministry in consultation with community groups and the Canadian Council on Accreditation of Mental Health Facilities.

IV. REGIONAL AUTHORITY FOR ALL COMMUNITY HEALTH SERVICES

Legislation could be developed which facilitated the development of an integrated service delivery system for a range of health and social services, including community mental health services.

Like the third approach, the legislation would establish the mandate of a regional authority. However, unlike the first three approaches, the scope of the authority would extend beyond mental health services to include a range of health and social services. One option would be to include programs funded by the Ministry of Community and Social Services as well as the Ministry of Health. Possibilities include health institutions, community health services, independent health facilities, residential programs, mental health programs, support services for mentally and physically disabled persons, support services for seniors, family violence programs and other services to children and families.

It is anticipated that the structure and responsibilities of the authority could be phased in over a number of years. Initially, the local authority could restrict its activities to community services, but have the potential to expand the range of services to include hospitals and other institutions.

As described in the third approach, the legislation would outline the principles of service delivery, the range of services to be provided and the administrative framework for an integrated service system.

1. Regional Authority
   It is anticipated that the role of the local authority would evolve as the community service system becomes more integrated. The range of the responsibilities of individual authorities would be negotiated centrally and locally. The delegation of authority could include co-ordination, resource allocation and management functions.
2. Planning
   The legislation would provide support for the local planning activities of District Health Councils and other planning bodies. The regional authority would provide assistance to and help to co-ordinate planning within its geographic area.
3. Funding
   The legislation could facilitate an integrated approach to the funding of health and social services. The mechanism for achieving this goal would require further discussion.

4. Administrative Framework

The regional authority could be structured as a joint Ministry of Health/Ministry of Community and Social Services field system. It could also be created as a separate body comprised of consumer representatives, service providers and municipalities. Members could be drawn from the District Health Council(s), an inter-agency council or other social service body. The structure and governance of the authority could vary locally. A number of approaches have been suggested including: municipal government, an elected special purpose body, i.e. school board, a body appointed from the membership of existing planning organizations, a newly appointed special purpose body or a member of existing planning groups.

APPENDIX C

SUB-COMMITTEE ENDORSED RECOMMENDATIONS ADDRESSING NATIVE ONTARIANS' CONCERNS

RECOMMENDATIONS

1. That any legislation dealing with community mental health contain provisions for both professional in-service training and basic paraprofessional training for native counsellors.
2. The numbers of community-based mental health workers must be increased to reflect the needs of the community and the demands placed upon their services. Early diagnosis and intervention are key to providing early treatment and reducing the need for hospital admissions.
3. Programming in mental health must focus on primary prevention (health promotion), secondary prevention (education of high-risk groups), and tertiary prevention (treatment and chronic care services and community follow-up). In native communities, we see only tertiary care being provided.
4. Crisis intervention and prevention are priorities for our communities. Due to geographical isolation, the need for a 24-hour crisis telephone service is a priority, but it cannot function without the support of local crisis teams.
5. Although we advocate highly for native community-based mental health workers, we also view the services of specialists in psychiatry as a necessary component of a comprehensive mental health service. Any legislation should have provisions and incentives for these practitioners to make consultation visits to our communities for diagnosing and treating psychiatric problems. Teaching local service providers could also be a role, and compensation under Ontario health insurance should be assured.

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